Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RICHARD SEXTON, MD
5209 TORTUGA TRAIL
AUSTIN, TX 78731

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-11-1510-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I billed the correct amount, however only $650 was paid, since the billing for impairment rating calculation for the injuries to the head and chest was denied. The EOR stated that "documentation only indicates that range of motion was performed on the upper extremity. The documentation does not indicate ROM being performed for the other two body region [sic] (cervical or spine/pelvis)". This was not a valid reason to deny reimbursement, since calculation of range or motion was not required for these later two impairments to be reimbursed."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office reimbursed Dr. Sexton in accordance with Rule 135.204(i)(1) $350.00 for 99456 W5-WP(MMI) plus $300 for 99456 W5-WP(IR). Other line items billed were denied for ANSI Code 50-these are non covered services because this is not deemed a medical necessity by the payer as documentation did not support the evaluation of the 2 additional body areas. The explanation of benefits added a comment stating 'Documentation only indicates that range of motion was performed on the upper extremity. The Documentation does not indicate ROM being performed for the other two body regions (cervical or spine/pelvis).'

In review of the Designated Doctor report submitted in the dispute packet, the provider evaluated the wrist, head, and chest wall, giving an impairment rating of 0% using range of motion for the wrist and digits of the upper extremity which allows a reimbursement of $300.00. The report shows the injured worker stated to the designated doctor that the contusions of the chest wall and head had resolved; therefore he recorded 0% impairment without evaluating for such body areas as there was no evaluation or testing measurements for the head and chest included in the report."

Response Submitted by: State Office of Risk Management, PO BOX 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2010	99456-W5-WP	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 06, 2010
   - 50 – THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.: DOCUMENTATION ONLY INDICATES THAT RANGE OF MOTION WAS PERFORMED ON THE UPPER EXTEMITY [sic] AND HANDS ONLY - WHICH IS ONE BODY AREA. THE DOCUMENTATION DOES NOT INDICATE ROM BEING PERFORMED FOR THE OTHER TWO BODY REGION(CERVICAL OR SPINE/PELVIS).

   Explanation of benefits dated June 15, 2010
   - 50 – THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER.: DOCUMENTATION ONLY INDICATES AND SUPPORTS IR FOR THE RANGE OF MOTION PERFORMED ON THE UPPER EXTEMITY [sic] AND HANDS ONLY - WHICH IS ONE BODY AREA. THE DOCUMENTATION DOES NOT INDICATE ROM BEING PERFORMED FOR THE OTHER TWO BODY REGION(SPINE/PELVIS OR LOWER EXTREMITIES/FEET)
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
   - T14 – APPEAL/RECONSIDERATION BASED ON MEDICAL NECESSITY. YOU MAY SUBMIT REQUEST FOR IRO REVIEW NO LATER THAN 45 DAYS FROM NOTICE.

Issues

1. Has the Designated Doctor (DD) Examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The Respondent has utilized the denial code "50 – THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER" but has explained in line item comments on the explanation of benefits that the denial is based on "documentation does not indicate ROM being performed for the other two body regions.." The review will proceed with application of medical fee guidelines in 28 Texas Administrative Code §134.204 and a review of supporting documentation.
2. The provider billed a total of $950.00 total for CPT code 99456-W5-WP among four line items. Review of the documentation supports that the doctor performed an examination for MMI for one line item. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Documentation supports that an IR was done to wrist (upper extremity) as a first musculoskeletal body area defined in §134.204(j)(4)(C)(i)(II) using Range of Motion (ROM) which has a MAR of $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). This portion of the total billing has been paid by respondent at $650.00 and is not in dispute. The dispute is over IR of additional body areas to non-musculoskeletal areas (contusions of the chest wall and head).

   The calculation of reimbursement for a non musculoskeletal IR are based on 28 Texas Administrative Code §134.204 which states in part (j)(4)(D)(iv) and (v):

   (iv) When there is no test to determine an IR for a non-musculoskeletal condition:
   (I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category.
   (II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings.
   (III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.

   (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

The requestor did not submit documentation to support any of the above methods of evaluation. In fact the requestor states, "For contusions of the chest wall and head, the claimant reports that these injuries have resolved, therefore 0% permanent impairment is similarly assigned for these injuries." Therefore, no additional reimbursement is due.

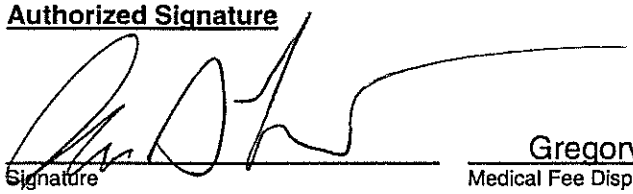
Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature



Signature | Gregory Fournerat, Medical Fee Dispute Resolution Officer | November 10, 2011, Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.